ALERT

# To: DME Providers

## DME Updates

Effective November 15, 2006 HCPC codes K0813- K0816, K0820-K0831, K0835-K0843, K0848-K0864, K0868-K0871, K0877-K0880, K0884-K0886, K0890, K0891 and K0898 will be used as appropriate for related motorized wheelchairs. Effective November 15, 2006, procedure codes K0010, K0011, K0012 and K0014 will no longer be used to cover motorized power wheelchairs.

Alabama Medicaid has added or revised medical policies for the **CPAP/BIPAP Machines, Alternating Pressure Pad With Pump or Gel–Like Pressure Pad for Mattress, Short Term Rental of Durable Medical Equipment, Enteral Nutrition Equipment and Supplies, Total Parenteral Nutrition Equipment and Supplies, Hospital Beds and Accessories and Ventilator.** This ALERT Newsletter contains these added or revised medical policies. Medical policies for the CPAP/BIPAP Machines and Ventilator will also be published in Chapter 14 and Appendix P of the January 2007 DME Provider Manual. The remaining medical policies listed above will not be in Chapter 14 and Appendix P of the January 2007 DME provider Manual.

## Medical Criteria Updates

### CPAP Devices – E0601

1. Covered for children under age 21 with an EPSDT Screening
2. The prescribing physician specializes in pulmonary, neurology or is a board certified sleep specialist and documents the recipient meets the following conditions:
    a. Patient diagnosed with obstructive sleep apnea, upper airway resistance Syndrome, or mixed sleep apnea;
    b. Diagnosis is supported by associated signs and symptoms of; craniofacial malformations, neuromuscular disorders, cardiopulmonary or metabolic disorders, morbid obesity or adenotonsillar hypertrophy, tracheomalacia, tracheostomy complications or anomalies of the larynx, trachea and bronchus that can be documented to improve and maintain airway patency and oxygenation through the use of CPAP.

### Documentation Required:

1. Results of sleep study recorded for at least 360 minutes or 6 hours.
2. For patients less than six months old sleep study is accepted if duration of sleep study is 240 minutes or 4 hours.
3. Sleep study must be performed within 6 months of prescribing device and documents:
    a. Respiratory disturbance index (RDI) or apnea/hypopnea index (AHI) $\geq$ 5 per hour of recorded sleep
    b. At least 30 apneas and/hypopneas within the sleep study period
    c. A reduction on CPAP in the patient's sleeps events of at least 50%

Initial approval will consist of up to three months of therapy. At recertification a statement from the physician must indicate the recipient's overall condition has not changed and that CPAP Therapy is still medically necessary for the duration of the time frame remaining on the EPSDT screening. Recertification is required until the recipient no longer meets the criteria or the device is removed from the home.

The CPAP device will be a continuous monthly rental item. All maintenance, supplies and replacement parts are included in the monthly rental price.

**NOTE**: Upon initial approval of the CPAP machine, recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks is covered in the rental price and no additional reimbursement is available.

## BIPAP Devices - E0470, E0471, E0472

1. Covered for children under age 21 with an EPSDT Screening
2. The prescribing physician, either specializing in pulmonary, neurology or board certified sleep specialist must document that the recipient meets the following conditions:
   a. Patient diagnosed with obstructive sleep apnea, upper airway resistance syndrome, or mixed sleep apnea;
   b. Patient has had an unsuccessful trial on CPAP, or Patient is 5 years of age

   **Documentation is required:**

   - Results of sleep study recorded for at least 360 minutes or 6 hours.
   - For patients less than six months old, duration of sleep study is 240 minutes or 4 hours.
   - Sleep study must include:
     - A respiratory disturbance index (RDI) or apnea/hypopnea index (AHI) $\geq$ 5 per hour of recorded sleep
     - At least 30 apneas and/hypopneas within the sleep study period
     - A reduction on CPAP in the patient's sleeps events of at least 50%.

Initial approval will consist of up to 90 days of therapy. At recertification a statement from the physician must document recipient's overall condition has not changed and the BIPAP is still medically necessary. Documentation of patient's compliance with treatment is required. For continued coverage a repeat sleep study is required if last study was conducted more than 2 years ago.

The BIPAP will be a ten month capped rental item. The monthly rental payment includes delivery, in-service for caregiver, maintenance, repair and supplies. After the 10 month rental period ends the device is considered a purchased item paid in full by Medicaid for the recipient. Supplies and repairs for the BIPAP require prior authorization and are only covered after the machine is purchased.

## Alternating Pressure Pad (APP) With Pump/Gel-Like Pad for Mattress - E0180, E0181, E0185

An APP or Gel/Gel like pressure pad is considered medically necessary if patient is bed confined for at least 75 to 100% of the time and the patient meets the following criteria:

1. Patient is unable to physically turn or reposition self
2. Patient is medically at risk for skin breakdown (define criteria as to why)
3. Recipient's care plan must document the following:
   a. Caregiver/recipient has had education on prevention /management of pressure ulcers
   b. Regular health care assessment at least every 30 days
   c. Caregiver/recipient understands and can performs turning and positioning
   d. Caregiver/recipient understands management of moisture/incontinence
   e. Recipient has nutritional assessment documenting nutritional status

Initial approval of the APP requires prior authorization that will be good for up to 6 months only. If physician documents that recipient will need APP longer than six months the APP will become a capped rental to purchase item. The monthly rental payment includes delivery, in service for caregiver, maintenance, and repair and supplies if applicable. The gel/gel like pressure pad will be purchased as this item is not considered reusable. .

## Short Term Rental Policy

Certain Durable Medical Equipment items prescribed as medically necessary will be rented if needed on a short term basis. Short term rental is described as (6) months or less. The procedure codes will be indicated on the fee schedule with an **RR** in the MOD field for rental.

Medicaid payment for short term rental will be made under the following conditions:

1. A written order for medical equipment documenting the number of months medical equipment will be needed; and
2. Documentation that establishes medical necessity for short term rental of the equipment.

Initial approval will consist of up to 90 days only. If recipient needs the equipment after the initial 90 day period, written documentation must be submitted that demonstrates continued medical necessity.

If equipment continues to be medically necessary longer than six months, a capped rental is established, previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price of the equipment.

## Enteral Nutrition Equipment and Supplies

**B9002, B4034, B4035, B4036, B9998, E1399 (EPSDT only)**

**B4081, B4082, B4086, A4213 (entire Medicaid population)**

Enteral nutrition equipment and supplies are covered for children under the age of 21 with an EPSDT Screening and Referral. Recipients age 21 and above (with noted limitations) qualify based on medical necessity and prior authorization when the following criteria are met:

1. The recipient meets the criteria for enteral nutrition; and
    a. Recipients less than 21 years of age and record supports that greater than 50 % of need is met by specialized nutrition; and
    b. Recipients is 21 years of age and greater and record supports 100 % of need is met by specialized nutrition.
2. Patient can not sustain through oral feedings and must rely on enteral nutrition therapy administered by nasogastric, jejunostomy, or gastrostomy tubes.
3. Prior authorization requests is required for Enteral Nutrition Equipment and Supplies (B9002, B4034, B4035 B4036, B9998). Prior authorization requests must be submitted with verification that all medical criteria have been met.
4. Enteral nutrition for adults 21 years of age and above is provided through bolus feeds only (A4213).

## Total Parenteral Nutrition (TPN) Equipment and Supplies -

**B9004, B9006 , B4081, B4082, B4086**

TPN Equipment and Supplies are provided for all Medicaid recipients based on medical necessity and require prior authorization when the following criteria are met:

1. The patient has met the criteria for specialized nutrition (TPN)

The recipient meets the criteria for enteral nutrition; and

    a. Recipient is less than 21 years of age and record supports that greater than 50 % of need is met by specialized nutrition.
    b. Recipient is 21 years of age and greater and record supports 100 % of need is met by specialized nutrition.

## Hospital Beds (E0250, E0255, E0280, E0303, E0304,)

Hospital bed must be prescribed as medically necessary by the physician and one of the following criteria must be met:

1. Recipient positioning of the body not feasible on an ordinary bed.
2. Recipient has medical conditions that require head of bed elevation.
3. Recipient requires medical equipment which can only be attached to the hospital bed.

At least one of the criteria listed above must be met as well as any of the following for coverage of variable height hospital bed:

1. Recipient has medical condition or injuries to lower extremities and the variable height feature allows recipient to ambulate by placing feet on the floor while sitting on edge of bed.
2. Recipient's medical condition prohibits transfer from bed to wheelchair without assistance.
3. Severely debilitating diseases and conditions require the need of the variable height bed to allow recipient to ambulate or transfer.

Medicaid coverage of the heavy duty, extra wide bed with side rails and mattress is available for weight capacities greater than 350 pounds but less than 600 pounds. The extra heavy duty, extra wide bed with side rails and mattress is available for weight capacities greater than 600 pounds. Replacement mattresses for these heavy duty beds can be obtained using procedure code E1399.

## Hospital Bed Accessories

**E0271, E0275, E0276, E0280, EE0310 E0621, E0630, E0910, E0911, E1399**

Hospital bed accessories must be prescribed as medically necessary, require prior authorization and medical documentation must be submitted justifying the need.

If a hospital bed is medically necessary and needed for six months or less the equipment will be rented. This policy is applicable for all Medicaid recipients. If the equipment continues to be medically necessary and is needed longer than six months, a capped rental is established, previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price.

## Ventilator - E0450, E0461, E0463

Volume Ventilators and Pressure Ventilators are covered for children with an EPSDT Screening when prescribed by a physician as medically necessary.

The recipient must meet the following conditions:

1. Medically dependent on a ventilator for life support at least 6 hours a day;
2. Has been dependent on ventilator for life support for at least 30 consecutive days and medical documentation from the recipient's primary physician indicates long term dependency on ventilator support.
3. Except for the availability of respiratory care services (ventilator equipment) would require respiratory care as an inpatient in a hospital, NF or ICF/MR and would be eligible to have payment made for inpatient care under the state plan;
4. Has adequate social support services to be cared for in the home; and

5. Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual without continuous technical or professional supervision. (Reference 42 CFR Section 440.185 Respiratory care for ventilator-dependent individuals.)

The patient has at least one of the following conditions:

- Chronic respiratory failure,
- Spinal cord injury
- Chronic pulmonary disorders,
- Neuromuscular disorders, or
- Other neurological disorders and thoracic restrictive diseases.

Initial approval will be allowed for up to 12 months based on the EPSDT screening. Subsequent approvals will require documentation from the physician which substantiates that the recipient continues to meet the medical criteria and must indicate the recipient's overall condition has not improved sufficiently.

The Ventilator will be reimbursed as a monthly rental item. The monthly rental includes delivery, in-service for the caregiver, maintenance, a back up battery or power supply, all medically necessary supplies and repairs and on call service as necessary. Recertification is required until the recipient no longer meets criteria or the device is removed from the home.